

Community Health Plan Care Model

Presentation to the
Washington Association of Area Agencies on Aging

September 7, 2011

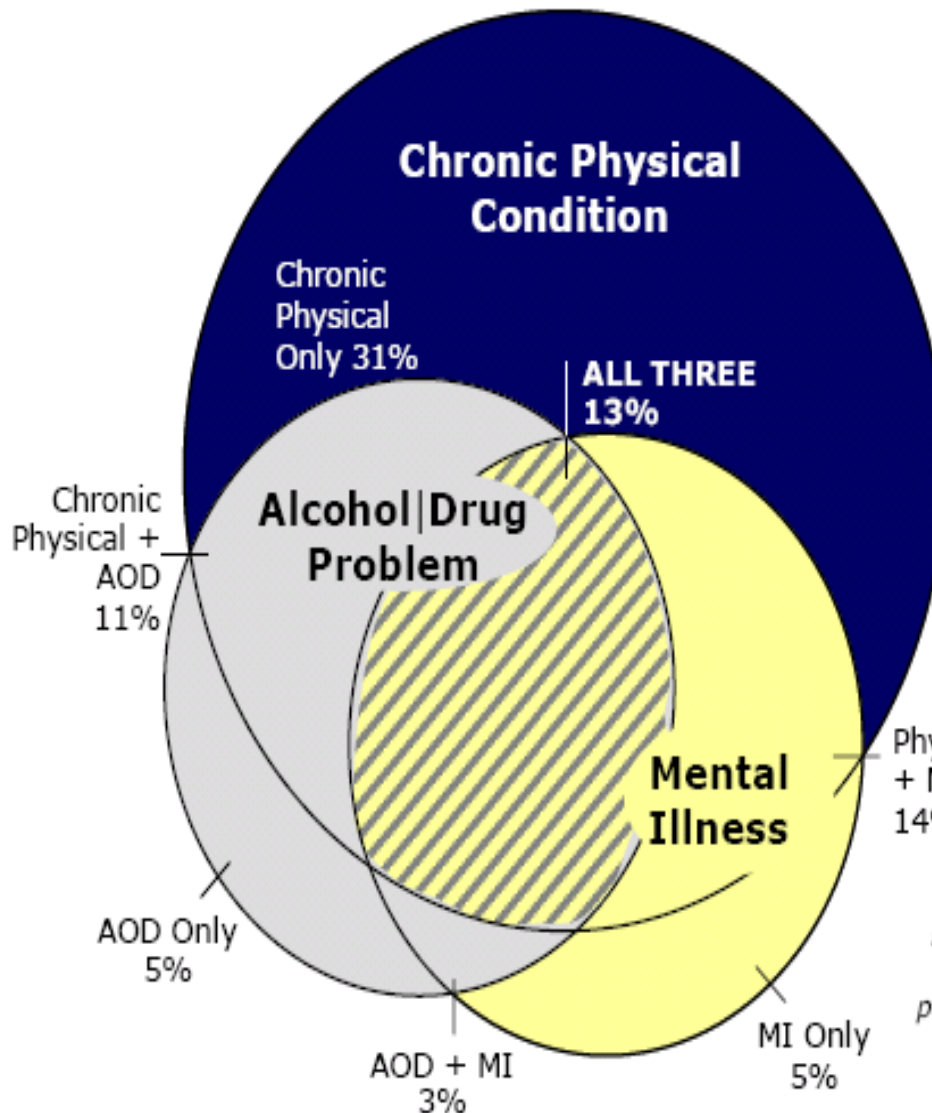
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Complexity of DL (GA-U) Population

Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified

31 percent had a chronic physical condition only



PRIMARY CONDITIONS	
Chronic Physical	69%
Mental Illness	36%
Substance Abuse	32%

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

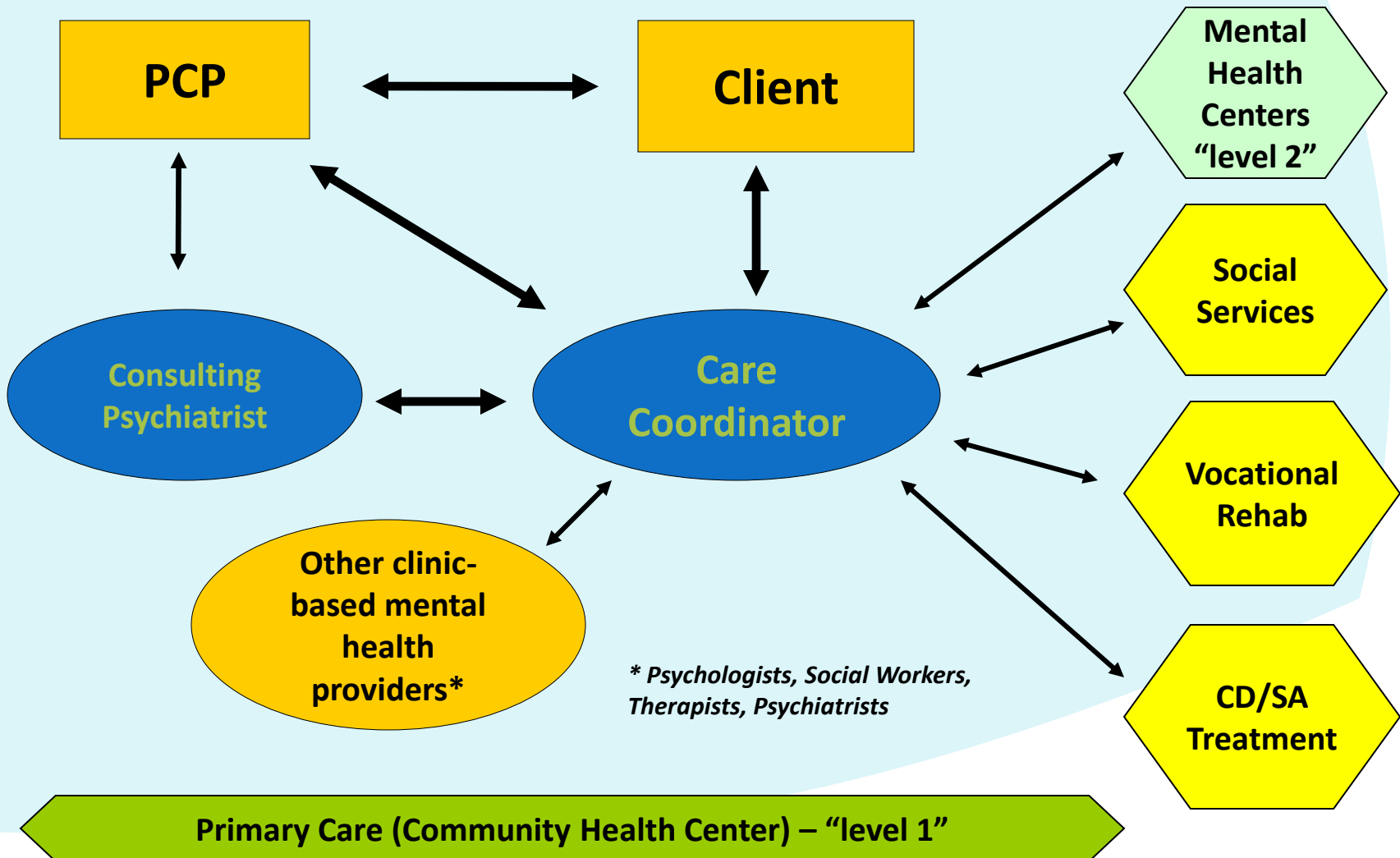
Planning Process

- ⦿ Gathered Stakeholders for a DL Summit
- ⦿ Established Steering Committee of Local Stakeholders
 - To determine care coordinator salary, screening tools, referral protocols
- Ongoing evidence-based training for providers through contract with University of Washington
- Delivery system ownership

Evidence for How to Improve Things

- Integrate / coordinate care between PCPs and CD / MH specialists
 - ‘patient-centered collaborative care’
 - 40 randomized controlled trials
- Use registries and close follow-up to make sure patients don’t fall through the cracks
- Follow measurable treatment outcomes, consult appropriate specialists, and adjust treatments if patients are not improving as expected (‘stepped care’)

CHPW's Care Coordination Model



Major Accomplishments

- Improved access to care for complex safety net populations:
 - Over 16,000 clients state-wide. Most can be served in primary care with appropriate support or in a CMHC in close collaboration with PC
- Fewer people fall through the cracks
 - Registry helps keep track of patients, facilitates systematic treatment change and allows performance-based contracting
- MH specialty consultation / care is systematically focused on patients who are challenging / not improving
- Benefits go beyond improved clinical outcomes: lower arrest rates and less homelessness
- A model for successful integration of primary care and behavioral health care for complex populations
(=> patient centered health care home)

Mental illness is the key driver of SSI disability caseload growth

**SSI caseload:
Up 24% since 2002**

81,192
TOTAL SSI

**Primary
Mental Illness**
41%
n = 33,289

**Other
Primary Illness**
59%
n = 47,903

2002

100,988
TOTAL SSI

**Primary
Mental Illness**
48%
n = 48,575

**Other
Primary Illness**
52%
n = 52,413

2009

**77% of SSI caseload growth since
2002 is due to growth in Mental**

**Growth
in All Other**
**= 23% of total
increase**
n = 4,510

**Growth in Primary
Mental Illness**
**= 77% of total
increase**
n = 15,286

TOTAL SSI CASELOAD INCREASE = 19,796



Potential to Benefit More Patients

- ① **Extend integrated behavioral health to additional populations – Healthy Options, Basic Health, SSI, Duals**
- ② **Broaden model of care to target patients with chronic medical conditions**
- ③ **Leverage community partnerships and expand beyond current setting – expanded networks of care**

Health Care Home for Complex Populations – *future* clinical + CHP

- ⦿ Bolster front-end work to **identify highest risk members**
 - Robust health risk assessment
 - Predictive modeling
- ⦿ **Expand to different disease states**
 - New capacity within clinical care teams
 - New additional supports to providers (disease registry, telehealth, more robust data)
- ⦿ Incorporate back-end **community-based outreach strategy** to ensure appropriate care for individuals who need extra assistance

Questions?